Claims and ICD-10

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Claim Forms

Paper Claim Forms

CMS1500 professional claim form

- www.nucc.org

UB-04 institutional claim form

- www.nubc.org

Both claim forms

- www.cms.hhs.gov

Includes field definitions and valid data for all fields

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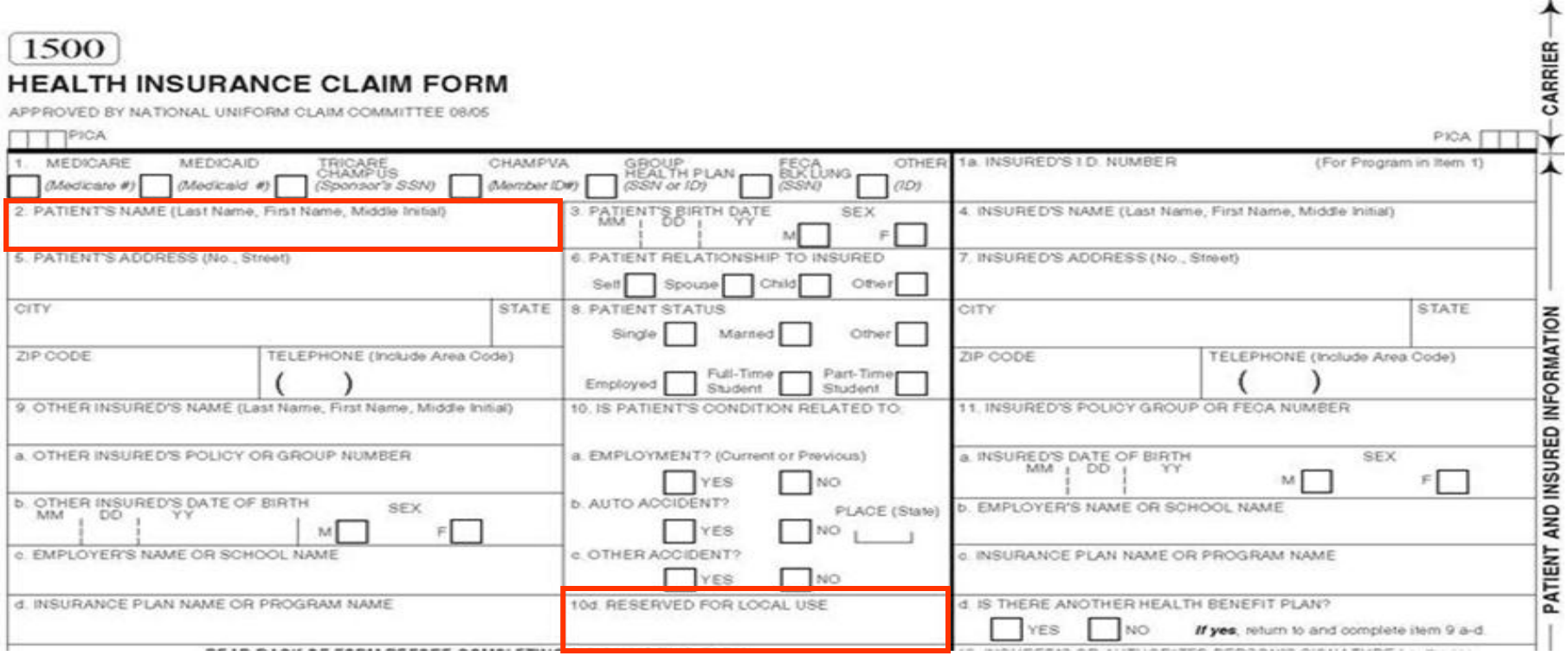
Professional Claim: CMS 1500


1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

CARRIER

PATIENT AND INSURED INFORMATION

Basic Requirements

- Client name
- Client ID (field 10d)

Conditional Fields

- Other insurance

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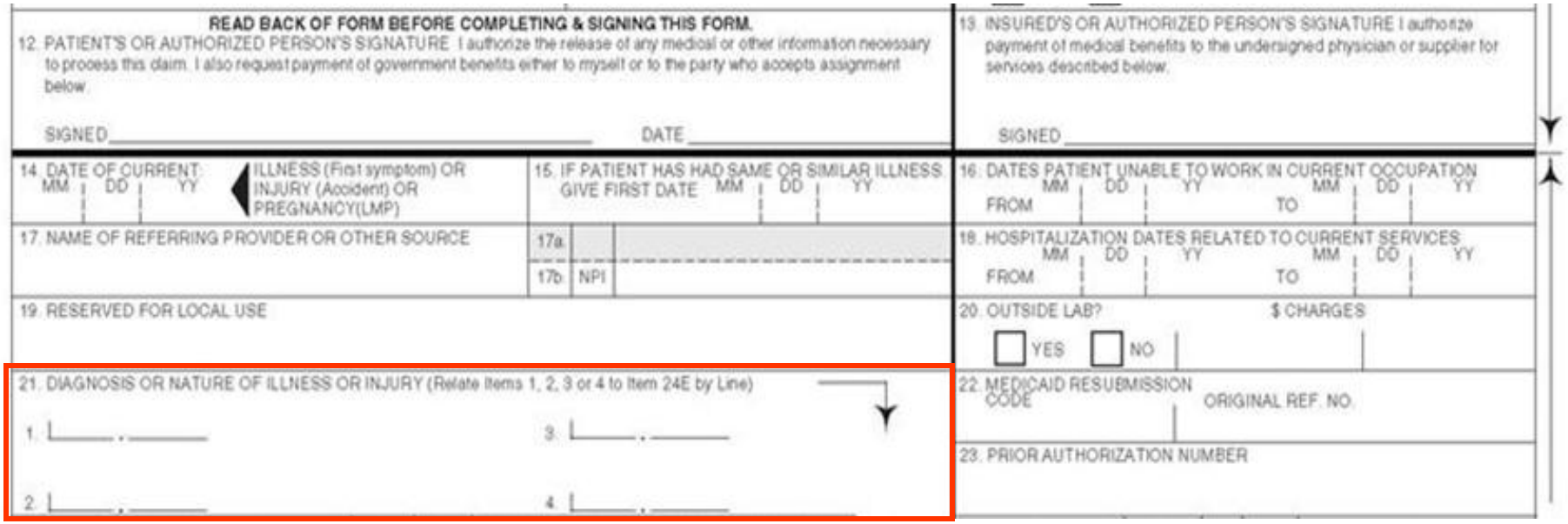
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 3.
2. 4.
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

Basic Requirements

- ICD-9 codes

Conditional Fields

- Referring NPI
- Passport
- Prior Authorization

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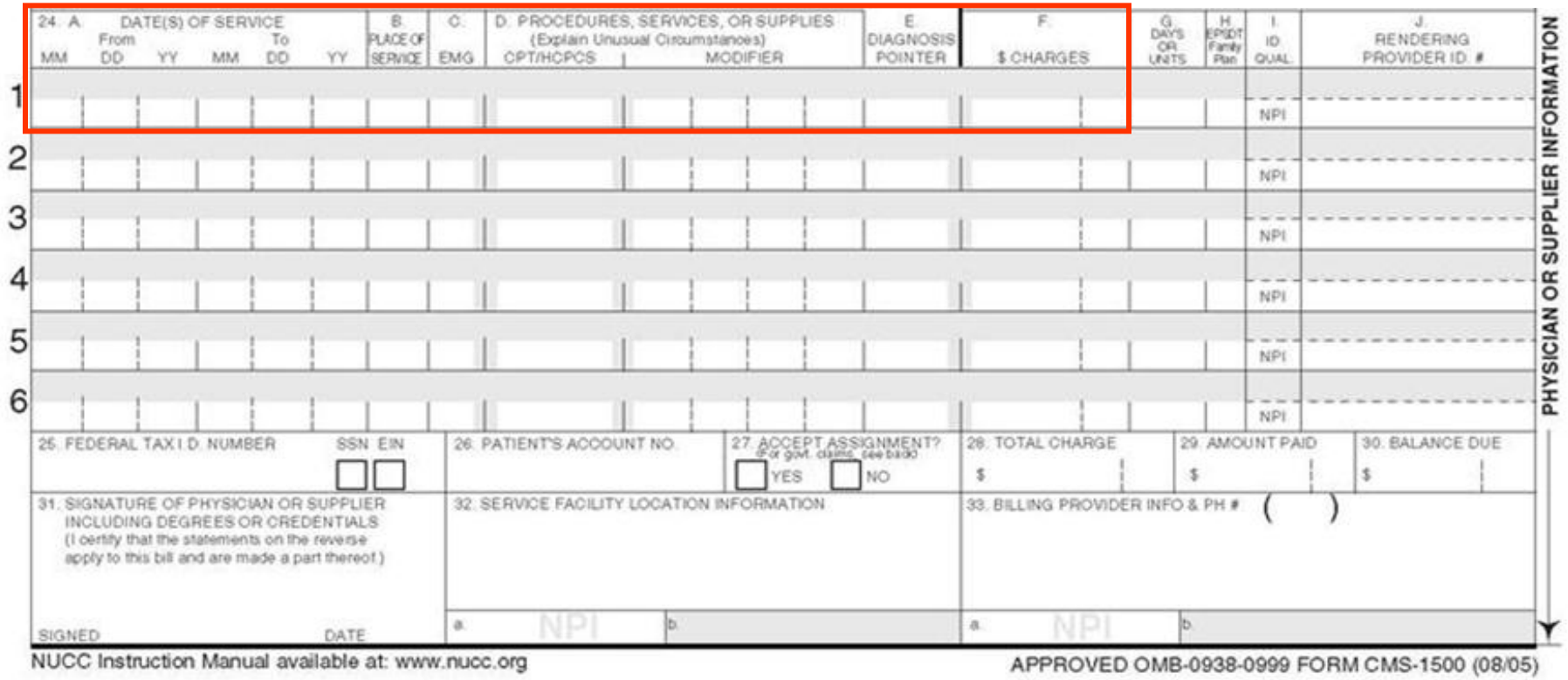

Basic Requirements

- Date of service
- Place of service
- Procedure codes
- Diagnosis pointer
- Usual and customary charges

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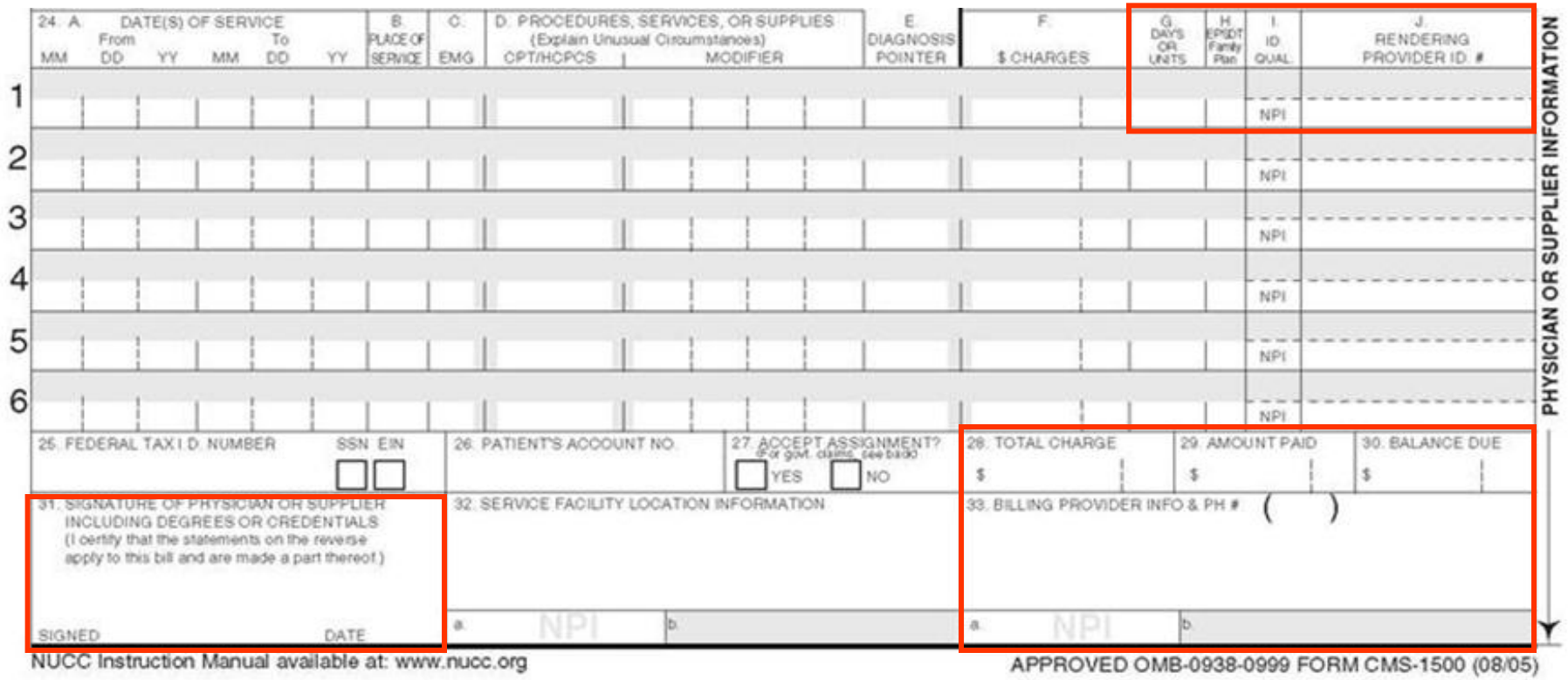

Basic Requirements

- Units
- Rendering Provider NPI/Taxonomy
- Authorized signature and date
- Total charges
- Montana Health Care Programs NPI (field 33a) and Taxonomy (field33b)

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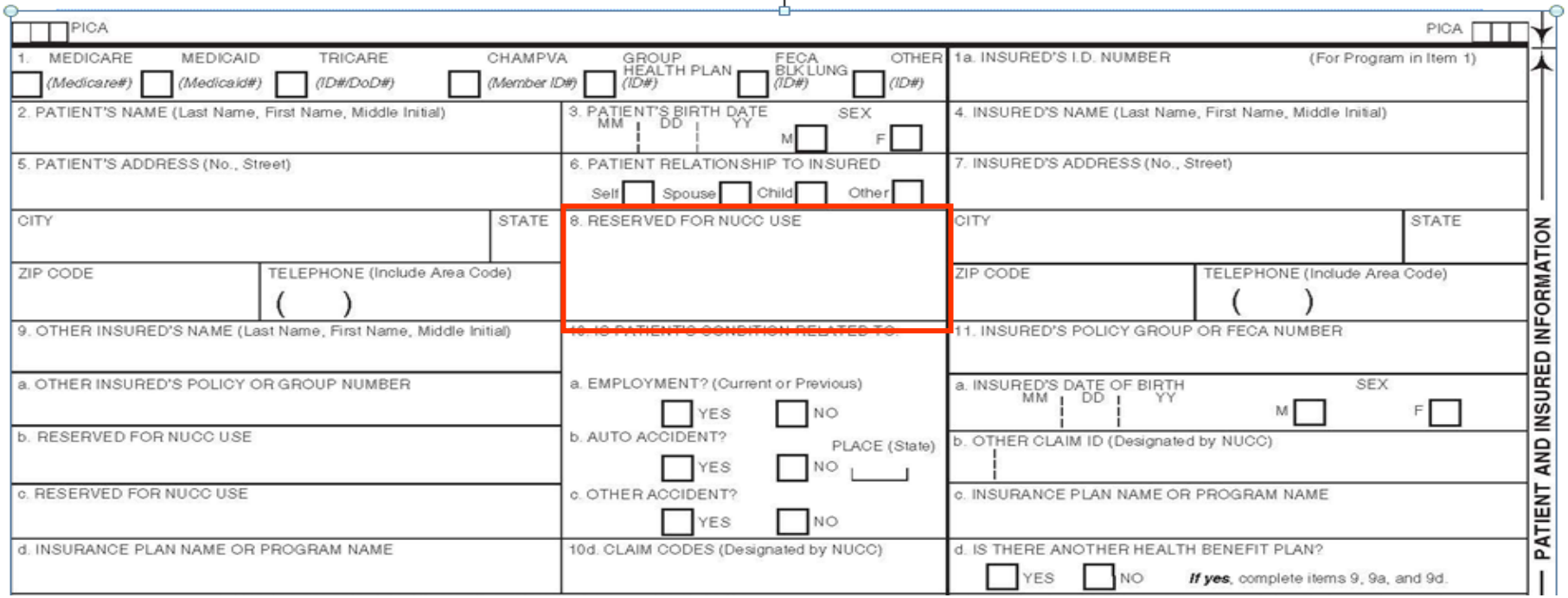
PICA

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

CMS 1500 Proposed Changes

- Field 8 reserved for NUCC use

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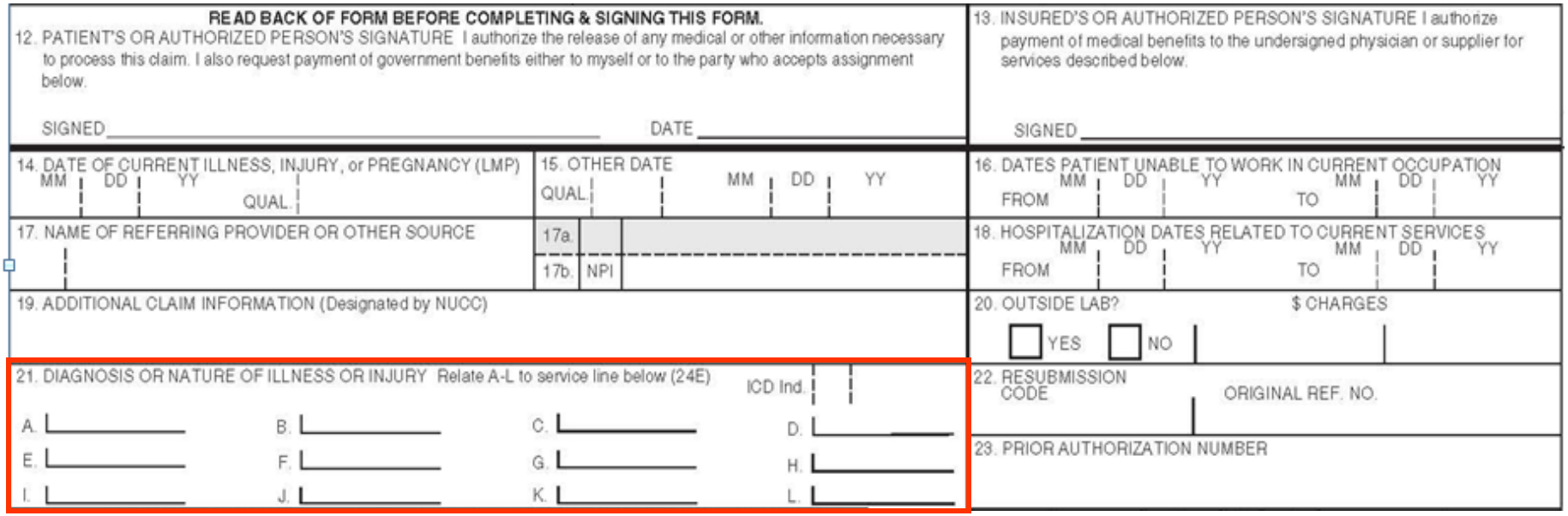
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM | DD | YY QUAL.
15. OTHER DATE QUAL. MM | DD | YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM | DD | YY FROM MM | DD | YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM | DD | YY FROM MM | DD | YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. B. C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

CMS 1500 Proposed Changes

- Diagnosis fields increased to 12
- Hold up to 7 characters

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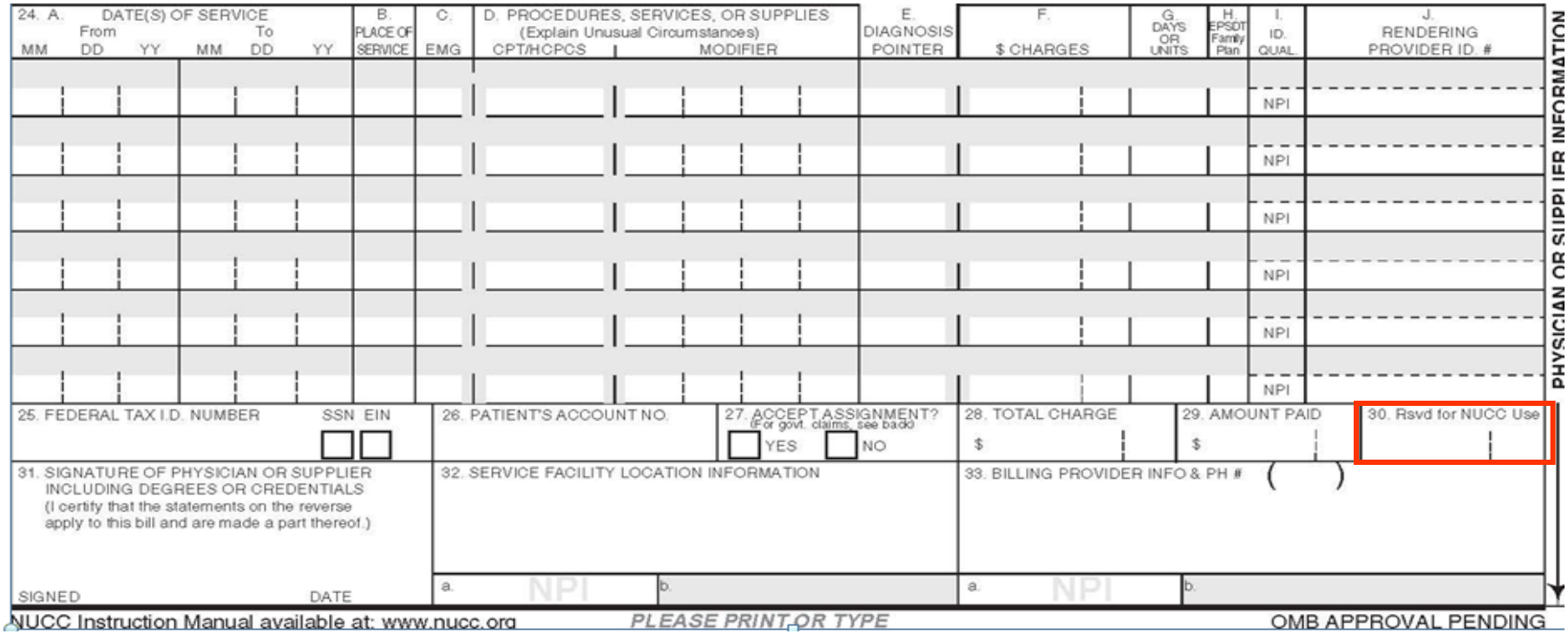

CMS 1500 Proposed Changes

- Field 30 reserved for NUCC use

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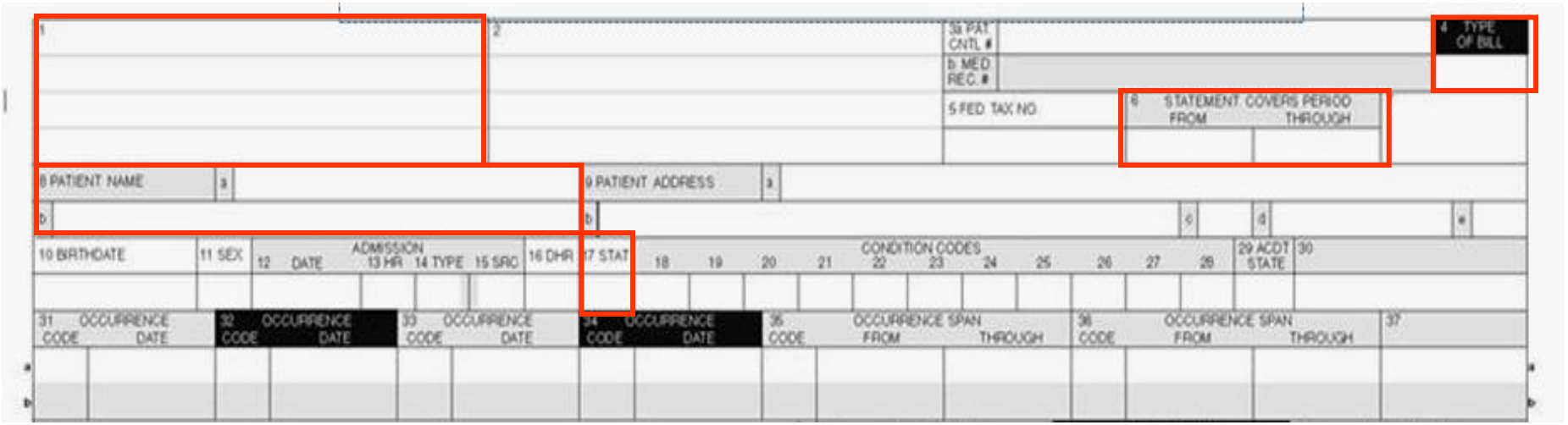
Institutional Claim: UB-04



Basic Requirements

- Provider's physical address
- Type of bill
- From and through dates of service
- Client name
- Client status (box 17)

Conditional Information

- Passport number/Exemption

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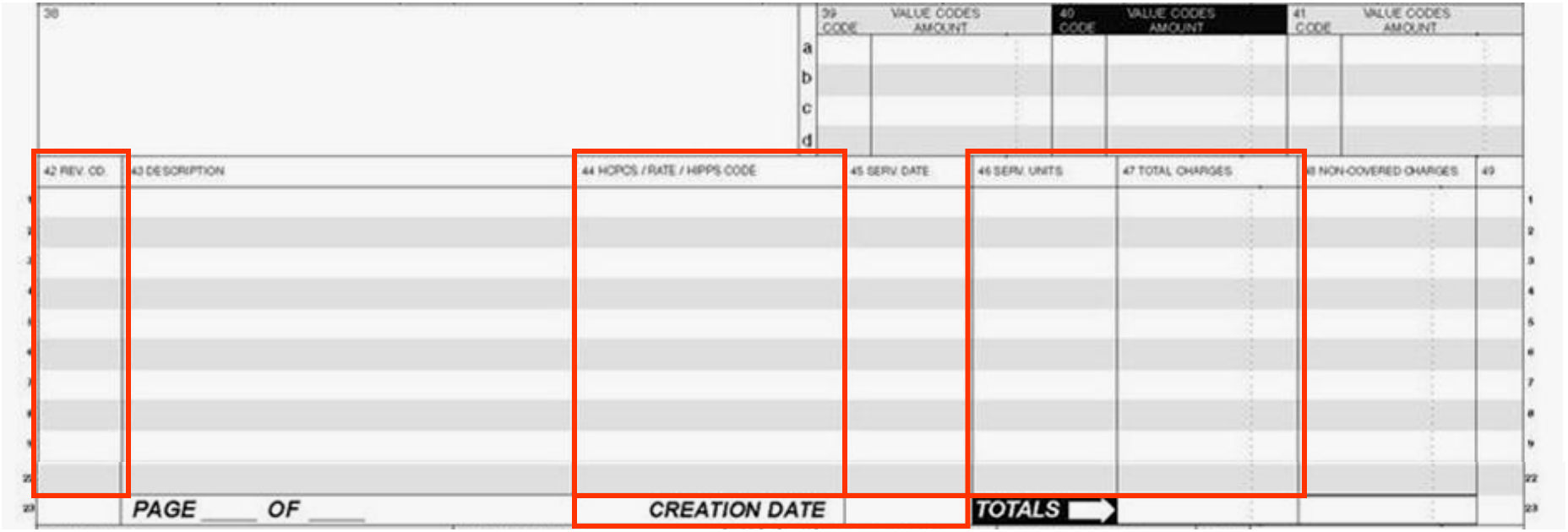

Basic Requirements

- Revenue codes
- CPT-4/HCPCS codes
- Service Units
- Charges
- Creation date

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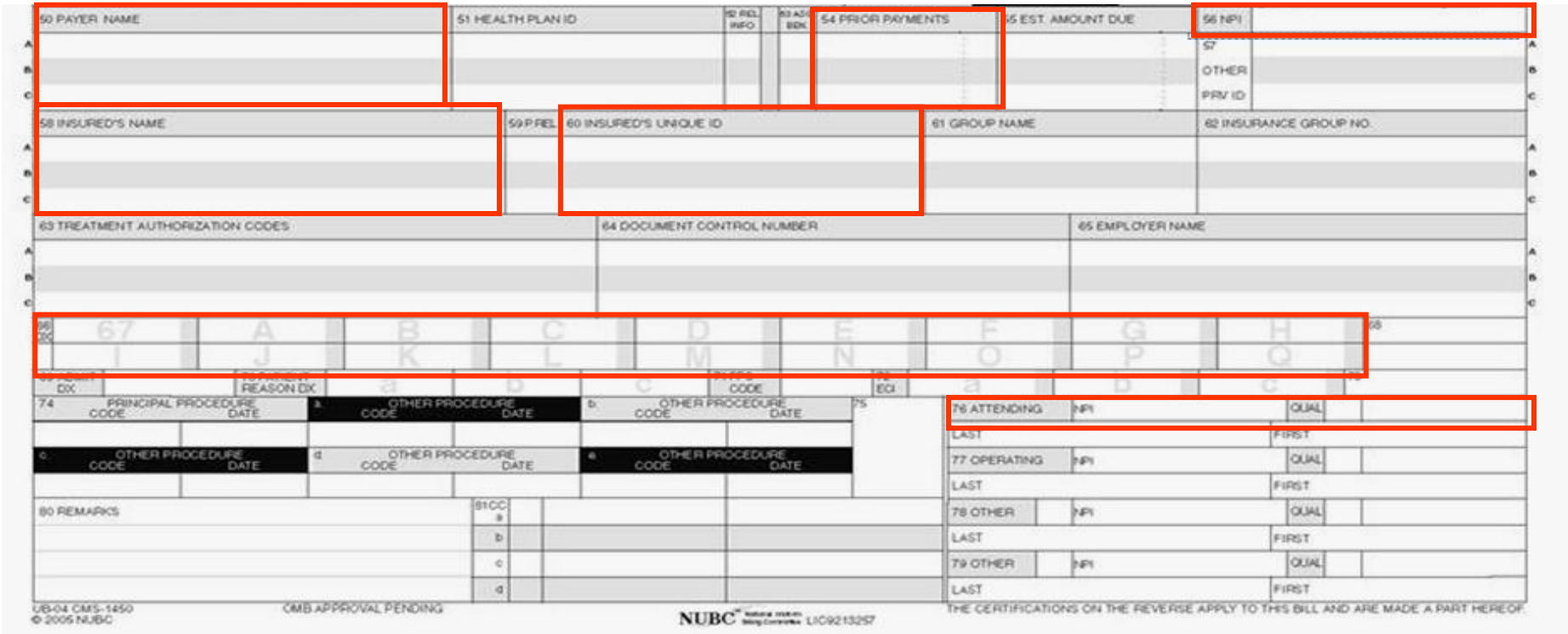

Basic Requirements

- Payer name
- Pay-to NPI (form locator 56)
- Client Name
- Client ID
- Primary diagnosis
- Attending provider NPI and Taxonomy

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UB-04

Conditional information

- Admission (inpatient)
- Condition codes
- NDC
- Service dates
- Treatment authorization
- Admitting diagnosis (inpatient) EMG
- Unlabeled (73) cost share indicator
- ICD-9 (inpatient only)
- Operating and other provider

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Dental Claim

Dental

Basic Requirements

- 2006 ADA form
- Complete the form in full
- Instructions can be found at
  - http://www.ada.org

Conditional Requirements

- Other coverage
- Orthodontics

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Electronic Claims

Ways to submit claims

- Practice management software
- Billing agent
- Clearinghouse
- WINASAP5010 software

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Electronic Billing Processing

- Upload electronic claims
- HIPAA 5010 format
- Screened for Montana specific edits
- Accepted, Rejected, or Errored out

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Common Questions

- Where do I find Montana specific electronic billing information?
- What is X12?
- What is the payer ID?
- When do claims cycle?
- Where is my EOB?

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WINASAP5010

- Free software developed by Xerox
- Support offered by Xerox EDI: 800-624-3958
- Submit all claim types
  - Institutional
  - Professional
  - Nursing Home
  - Dental

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Common WINASAP Questions

- Does Xerox keep a backup of my WINASAP files?
- Will WINASAP work with Microsoft Windows 8?
- Was my electronic file received?
- Why do the same claims keep processing?

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Remittance Advice

Available every Tuesday

- Web portal
  - www.mtmedicaid.org
  - Available 90 days
  - Save or print option
- 835 transaction
  - ANSI X12 format
  - Practice Management software conversion
  - Offered via clearinghouse

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Remittance Advice

Tips

- Visit the EOB R&R crosswalk
- Work all denials before resubmitting
- Do not post payments in a credit balance
- Do not resubmit claims in a Pended status

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Remittance Advice

```
1234567    Data, Test          07012011 07012011  1.000 99221 204.00   96.66
   ICN 21122000000000000 PATIENT NUMBER=10000

     0000111111 Fred T Flinstone M D
                              07022011 07022011  1.000 59514 1900.00  0.00     B22  B13 M86 B15 M80
                              07032011 07032011  1.000 99231 93.00    0.00     B22
                              07042011 07042011  1.000 99238 154.00   0.00     B22


****THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE ******
B13    PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED
       IN A PREVIOUS PAYMENT.
B15    PAYMENT ADJUSTED BECAUSE THIS PROCEDURE/SERVICE IS NOT PAID
       SEPARATELY.
B22    THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.
MA04   SECONDARY PAYMENT CANNOT BE CONSIDERED WITHOUT THE IDENTITY OF OR
       PAYMENT INFORMATION FROM THE PRIMARY PAYER. THE INFORMATION WAS EITHER
       NOT REPORTED OR WAS ILLEGIBLE.
M80    NOT COVERED WHEN PERFORMED DURING THE SAME SESSION/DATE AS A
       PREVIOUSLY PROCESSED SERVICE FOR THE PATIENT.
M86    SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE
       WITHIN SET TIME FRAME.
N286   MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.
107    CLAIM/SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING CLAIM/SERVICE
       WAS NOT PREVIOUSLY PAID OR IDENTIFIED ON THIS CLAIM
133    THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.
15     THE AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE
       BILLED SERVICES OR PROVIDER.
18     DUPLICATE CLAIM/SERVICE.
22     THIS CARE MAY BE COVERED BY ANOTHER PAYER PER COORDINATION OF BENEFITS.
9      THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE.
```

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ICD-10

- What is the ICD-10 implementation date?

- Where do I find information about ICD-10?

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Contact Information

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Questions?

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